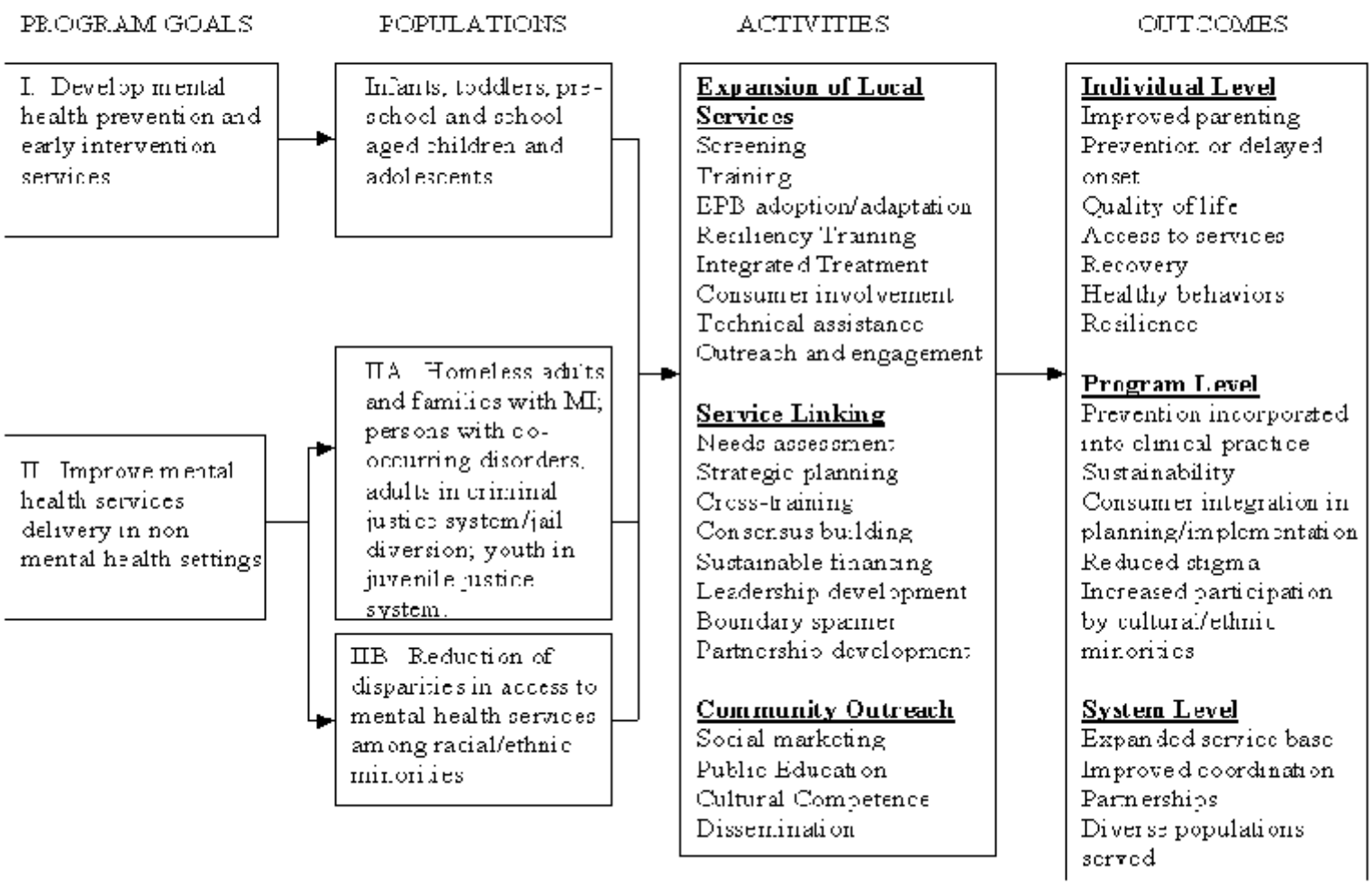
APPENDIX I: LOGIC MODEL FOR TCE– BUILD MENTALLY HEALTHY COMMUNITIES



Appendix II: References and Examples of Evidence-Based Programs

The organizations and resources listed below are not exhaustive, nor does the appearance of a program in the following list imply endorsement by the federal government. Rather, these listings are intended to assist grantees in formulating a response to the Guidance for Applicants (GFA) for *Building Mentally Healthy Communities*.

Infants, Toddlers, Preschool and School-Aged Children and Adolescents

The Center for Mental Health Services commissioned two papers to review the literature related to the prevention of mental disorders for children and adolescence. The first paper, written by Dr. David Olds and his colleagues at the Prevention Research Center for Family and Child Health, University of Colorado Health Sciences Center, addressed preventive interventions for mental disorders during the first five years of life. The second paper, written by Dr. Mark Greenberg and his colleagues at the Prevention Research Center for the Promotion of Human Development, Pennsylvania State University, addressed prevention programs for school-aged children ages 5 to 18. Dr. Olds report can be obtain from the Internet web site: **www.sshsac.org/PDFfiles/ReducingRisks.pdf** or **www.sshsac.org** click on Resources; then Resources Links; then Prevention; see #12. Dr. Greenberg's article can be downloaded from the web site: **http://www.prevention.psu.edu/**. Each paper describes a number of prevention interventions using a set of standards for inclusion as explained in the introduction. Risk factors and protective factors addressed by an intervention and the expected outcomes if the intervention is discussed.

Programs listed in the Olds et al. and the Greenberg et al. Working Papers commissioned by CMHS have been identified by experts as programs to prevent mental and behavioral disorders. *Some* programs identified by other organizations (*Blueprints for Violence Prevention* identified by the Center for the Study and Prevention of Violence or the National Registry of Effective Prevention Programs identified by the Center for Substance Abuse Prevention, SAMHSA) as violence or substance abuse prevention programs *may* also be *de facto* mental health

promotion or prevention programs. However, if an applicant decides to use a program that is *not clearly identified* as a program to prevent mental and behavioral disorders, he/she must explain clearly how the program will in fact prevent mental and behavioral disorders.

Other resources listed below provide a discussion of evidenced-based practices that they consider acceptable for use in community settings. Some programs that are listed in a domain other than mental health (e.g., violence prevention) could be used for mental health projects because the risk and protective factors addressed are shared. For example, a violence prevention protocol that addresses aggressive behavior in young children may also be viewed as a preventive intervention pertaining to the psychiatric diagnosis of conduct

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disorder.

It is essential that preventive interventions adopted for the first time by a grantee be done in collaboration with the researchers who designed the protocol or their designee to ensure quality implementation. In addition, the environmental context in which preventive and early intervention strategies are implemented needs to be assessed for supportive elements. For example, when a county mental health center collaborates with local school district to provide a social emotional skills program (such as PATHS) or with a number of daycare centers to provide teacher and parent training such as *The Incredible Years*, key people such as a school principal or a day care director must be committed to the endeavor and be willing to be openly support the adoption of the prevention strategy.

Examples of evidence based interventions that support a mental heath preventive or early intervention initiative are:

- ***The Incredible Years*** is a researched-based effective program that has been shown to reduce children's aggression and other behavior problems while increasing social skills. It was selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "exemplary" best practice program and as a "Blueprints" program, the Center for Substance Abuse Prevention (CSAP) as a "Model" program, and recommended by the American Psychological Division 12 Task force as a well-established treatment for children with conduct problems. This intervention is an example of one which could be use to prevent mental health problems, as well as an early intervention for a child with an externalizing disorder. Children ages 2 to 12 years, their parents and teachers, are eligible for the training series. Training workshops offering certification for each of the Parent, Child and Teacher programs are regularly offered in Seattle, Washington, and nationally. *The Incredible Years* was developed by Dr. Carolyn Webster-Stratton. For additional information, see **http://www.incredibleyears.com/index.html.**

  References:

  Webster-Stratton, C. (1999). *How to Promote Social and Emotional Competence in the Classroom.* London: Sage Publishers.

  Webster-Stratton, C. (1990a). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology* 18(5):479-492.

  Webster-Stratton, C. (1990b). Long-term follow-up of families with young conduct-problem children: From preschool to grade school. *Journal of Clinical Child Psychology* 19(2):144-149.

  Webster-Stratton, C. (1984). A randomized trial of two parent training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology* 52(4):666-678.

- **A psychoeducational preventive intervention** to prevent depression in children of parents with severe affective disorders has been developed by Dr. William Beardslee, Chairman, Department of Psychiatry, Children's Hospital, Boston, Massachusetts. Children aged 8-15 years and their parents were selected for a 6-10 session protocol tested in an experimental design. Follow-up studies indicate positive outcomes sustained for a three-year period. The preventive protocol is carried out by a mental health professional.

  References:

  Beardslee, WR. (1998). Prevention and the clinical encounter. *American Orthopsychiatric Association* 68(4):521-533.

  Beardslee, WR, Wheelock, I (1994). Children of parents with affective disorders: empirical findings and clinical implications. In Reynolds WM, Johnson HF (eds.): *Handbook of Depression in Children and Adolescents.* New York: Plenum, pp 463-479.

- **PATHS** (Providing Alternative THinking Strategies) is an empirically tested preventive intervention for elementary school aged children designed to enhance self-control, emotional awareness and problem-solving skills used in an interpersonal setting. It is a program for educators and counselors to be used in the school setting. The Instructional Manual including detailed six volumes of lessons is available from the researcher who designed the program. Outcome studies showed PATHS improves protective factors and reduces behavioral risk across a wide variety of types of children. For more information, contact Mark Greenberg, Ph.D., Director, Prevention Research Center, Pennsylvania State University, HDFS - Henderson Building South, Telephone (814) 863-0112 , FAX (814) 865-2530.

  References:

  Bierman, K., Greenberg, M. T., and the Conduct Problems Prevention Research Group (1966). Social skills in the FAST Track Program. In: R. DeV. Peters and R. J. McMahon (eds.). *Prevention and early intervention: Childhood disorders, substance abuse, and delinquency* (pp. 65-89). Newbury Park, CA: Sage.

  Greenberg, M. T., and Snell, J. (1997). The neurological basis of emotional development. In: P. Salovey (ed.) *Emotional development and emotional literacy* (pp. 92-119) . New York: Basic Books.

  Greenberg, M. T., and Kusche, C. A. (1993). *Promoting social and emotional development in deaf children: The PATHS Project*. Seattle: University of Washington Press.

  Greenberg, M. T., Kusche, C. A., Cook, E. T., and Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS Curriculum. *Development and Psychopathology* 7:117-136.

Kusche, C. A. and Greenberg, M. T. (1994) *The PATHS Curriculum*. Seattle: Developmental Research and Programs.

***Websites*:**

Center for School Mental Health Assistance, http://csmha.unmaryland.edu

The Center for School Mental Health Assistance (CSMHA) provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. They strive to support schools and communities in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. The Center offers a forum for training, the exchange of ideas, and promotion of coordinated systems of care that provide a full continuum of services to enhance mental health, development and learning in youth.

Safe Schools/Healthy Students Action Center,www.sshsac.org

The Safe Schools/Healthy Students Action Center works to assist Federal Safe Schools/Healthy Students grantees to fully attain their goals of interagency collaboration and adoption of evidence-based practices to reduce school violence and substance abuse, and to promote healthy development and resiliency. The Action Center also works to provide other local education agencies, communities, and families with access to resources and materials to enhance their ability to undertake collaborative efforts to prevent school violence and enhance resiliency. The clearinghouse can be use by the public. It provides links to prevention intervention resources.

Blueprints for Violence Prevention, www.colorado.edu/cspv/blueprints

The Center for the Study and Prevention of Violence (CSPV), with funding from the Colorado Division of Criminal Justice and the Centers for Disease Control and Prevention (and later from the Pennsylvania Commission on Crime and Delinquency), initiated a project to identify 10 violence prevention programs that met a very high scientific standard of program effectiveness--programs that could provide an initial nucleus for a national violence prevention initiative. Blueprints were designed to be very practical descriptions of effective programs to allow States, communities, and individual agencies to: (1) determine the appropriateness of an intervention for their State or community; (2) provide a realistic cost estimate for this intervention; (3) provide an assessment of the organizational capacity needed to ensure its successful start-up and operation over time; and (4) give some indication of the potential barriers and obstacles that might be encountered when attempting to implement this type of intervention.

The Collaborative to Advance Social and Emotional Learning (CASEL), **www.casel.org**

CASEL was founded in 1994 by Daniel Goleman and Eileen Rockerfeller Growald. CASEL's mission is to establish social and emotional learning (SEL) as an integral part of education from preschool through high school. Their goals are to: (1) advance the science of social

emotional learning, (2) translate scientific knowledge into effective school practice (3) disseminate information about scientifically sound educational strategies and practice (4) enhance training so that educators effectively implement high-quality SEL programs and (5) network and collaborate with scientists, educators, advocates, policy makers, and interested citizens to increase coordination of SEL efforts. Within the CASEL website are subheading including: http://www.casel.org/links.htm#prevention.

The Prevention Research Center for the Promotion of Human Development, College of Health and Human Development, The Pennsylvania State University, http://www.psu.edu/dept/prevention/

Thirty-four effective prevention programs are identified and discussed in detail in *Preventing Mental Disorders in School-Age Children: A review of the effectiveness of prevention programs. A review of the current state of preventing aggression, depression, and anxiety in children*. This report was produced for the federal Center for Mental Health Services (CMHS) and can be downloaded from the website.

School Mental Health Project/Center for Mental Health in Schools (UCLA), www.smhp.psych.ucla.edu

The Center's mission is to improve outcomes for youth by enhancing policies, programs, and practices relevant to mental health in schools, with specific attention to strategies that can counter fragmentation and enhance collaboration between school and community programs.

Homeless Adults and Families

The following evidence based practices should be considered when addressing specific needs or target populations:

- **Consumer involvement**. Involvement of formerly homeless mentally ill consumers in planning and delivery of services is an effective way to reach and engage the population.

  References:

  Glasser, N. (1999). Giving voice to homeless people in policy, practice, and research. In Fosburg, L.B., Dennis, D.L. (eds.) *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Delmar, NY: National Resource Center on Homelessness and Mental Illness.

  Van Tosh, L. (1993). *Working For A Change: Employment of Consumers/Survivors in the Design and Provision of Services for Persons Who Are Homeless and Mentally Disabled*. Rockville, MD: Center for Mental Health Services.

- ***Outreach and engagement***. Voluntary engagement in services is possible for the vast majority of homeless persons with mental illnesses through outreach. When skilled outreach teams are available, involuntary treatment is not necessary to reach most homeless persons with serious mental illnesses.

  References:

  Bybee, D., Mowbray, C.T., Cohen, E.H. (1995). Evaluation of a homeless mentally ill outreach program: Differential short-term effects. *Evaluation and Program Planning* 18(1):13-24.

  Lam, J.A., Rosenheck, R. (1999). Street outreach for homeless persons with serious mental illness: Is it effective? *Medical Care* 37(9): 894-907.

  Morse, G.A., et al. (1996). Outreach to homeless mentally ill people: Conceptual and clinical considerations. *Community Mental Health Journal* 32(3): 261-274.

  Tsemberis, S., Elfenbein, C. (1999). A perspective on voluntary and involuntary outreach services for the homeless mentally ill. *New Directions for Mental Health Services* 82: 9-19.

  Witheridge, T.F. (1991). The active ingredients of assertive outreach. *New Directions form Mental Health Services* 52: 47-64.

- ***Assertive Community Treatment***. Service delivery using ACT or similar multidisciplinary teams are more effective for homeless persons with mental illnesses than other methods primarily due to regular assertive outreach, lower caseloads, and multidisciplinary nature of services available on these teams.

  References:

  Burns, B.J., Santos, A.B. (1995). Assertive community treatment: An update of randomized trials. *Psychiatric Services* 46(7): 669-675.

  Dixon, L.B., et al. (1995). Modifying the PACT model to serve homeless persons with severe mental illness. *Psychiatric Services* 46(7): 684-688.

  Lehman, A.F., et al. (1997). A randomized trial of Assertive Community Treatment for homeless persons with severe mental illness. *Archives of General Psychiatry* 54: 1038-1043.

Morse, G. (1999). A review of case management for people who are homeless: Implications for practice, policy, and research. In Fosburg, L.B., Dennis, D.L. (eds.) *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Delmar, NY: National Resource Center on Homelessness and Mental Illness.

Morse, G.A., et al. (1997). An experimental comparison of three types of case management for homeless mentally ill persons. *Psychiatric Services* 48(4): 497-503.

Ziguras, S.J., Stuart, G.W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services* 51(11): 1410-1421.

- ***Comprehensive and Coordinated Services***. Services must be comprehensive and coordinated. Partnerships with other service systems (including housing) can increase residential and clinical stability and prevent homelessness.

References:

Dennis, D.L., Steadman, H.J., Cocozza, J.J. (2000). The impact of federal systems integration initiatives on services for mentally ill homeless persons. *Mental Health Services Research* 2(3): 164-174.

Federal Task Force on Homelessness and Severe Mental Illness (1992). *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness*. Washington, DC: Interagency Council on the Homeless.

Randolph, F., et al. Creating integrated service systems for homeless persons with mental illness: The ACCESS program. *Psychiatric Services* 48(3): 369-373.

Rosenheck, R., et al. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health* 88(11): 1610-1615.

Shern, D., et al. (1997). Housing outcomes for homeless adults with mental illness: Results from the Second-Round McKinney program. *Psychiatric Services* 48(2): 239-241.

- ***Mental Health and Substance Abuse Treatment***. Mental health and substance abuse services must be integrated at the clinical level.

References:

Drake, R.E., Osher, F.C., Wallach, M.A. (1991). Homelessness and dual diagnosis. *American Psychologist* 46(11): 1149-1158.

Goldfinger, S.M. (1990). Homelessness and schizophrenia: A psychosocial approach. In Herz, M.I., Keith, S.J., and Docherty, J.P. (eds.), *Handbook of Schizophrenia. Psychosocial Treatment of Schizophrenia, Vol. 4.* New York, NY: Elsevier Science Publishers, 1990

Susser, E., Goldfinger, S., White, A. (1990). Some clinical approaches to the homeless mentally ill. *Community Mental Health Journal* 26(5): 463-480.

- ***Housing***. Housing is an essential element in the prevention and stabilization of persons who are homeless and mentally ill. Many homeless people with serious mental illnesses can move directly from homelessness to independent housing with supports. The transition from homelessness to housing is a critical time that needs intensive supports and attention. Supported housing as a model is preferred by most homeless people with serious mental illnesses and appears to be effective in maintaining residential and psychiatric stability over time.

References:

Goldfinger, S.M., Schutt, R.K. (1996). Comparison of clinicians' housing recommendations and preferences of homeless mentally ill persons. *Psychiatric Services* 47(4): 413-415.

Hurlburt, M.S., Wood, P.A., Hough, R.L. (1996). Providing independent housing for the homeless mentally ill: A novel approach to evaluating long-term longitudinal housing patterns. *Journal of Community Psychology* 24(3): 291-310.

Lipton, F.R., et al. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiaric Services* 51(4): 479-486.

Proscio, T. (2000). *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness.* New York, NY: Corporation for Supportive Housing

Shern, D., et al. (1997). Housing outcomes for homeless adults with mental illness: Results from the Second-Round McKinney program. *Psychiatric Services* 48(2): 239-241.

Susser, E., et al. (1997). Preventing recurrent homelessness among mentally ill men: A "critical time" intervention after discharge from a shelter. *American Journal of Public Health* 87(2): 256-262.

Tsemberis, S., Eisenberg, R.F. (2000). Pathways to Housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services* 51(4): 487-493.

- ***Homeless Families***. Homeless families have very different service needs than individuals. In addition to their need for mental health and substance abuse treatment, housing, and employment, they also need daycare, transportation, and clinical services to address trauma related to domestic abuse and violence. While evidence-based practice is just being developed in this area, recent research suggests promising new directions.

References:

Bassuk, E.L., et al. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health* 87(2): 241-248.

Bassuk, E.L., et al. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association* 276(8): 640-646.

Melnick, S.M., Bassuk, E.L. (1999). *Identifying and Responding to Violence Among Poor and Homeless Women*. Newton Centre, MA: Better Homes Fund.

Rog, D.J., Holupka, C.S., McCombs-Thornton, K.L. (1995). Implementation of the Homeless Families Program: 1. Service models and preliminary outcomes. *American Journal of Orthopsychiatry* 65(4): 502-513.

Rog, D.J., et al. (1995). Implementation of the Homeless Families Program: 2. Characteristics, strengths, and needs of participant families. *American Journal of Orthopsychiatry* 65(4): 514-528.

- ***Treating Co-Occurring Disorders***. Integrating mental health and substance abuse treatment at the clinical level is the preferred method for working with persons who are homeless and mentally ill with co-occurring disorders. Collaborative and integrative efforts at the systems levels can help make clinical integration possible.

Carey, K.B. (1996). Treatment of co-occurring substance abuse and major mental illness. *New Directions for Mental Health Services* 70:19-31.

Drake, R.E., et al. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24(4): 589-608.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In Minkoff, K., Drake, R.E. (eds.), *Dual Diagnosis of Major Illness and Substance Abuse Disorder*. New Directions for Mental Health Services 50: 13-27.

Mueser, K.T., Drake, R.E., Miles, K.M. (1997). The course and treatment of substance use disorder in persons with severe mental illness. In Onken, L.S., Blaine, J.D., Genser, S., Horton, A.M. (eds.), *Treatment of Drug Dependent Individuals with Comorbid Mental Disorders*. National Institute of Drug Abuse Research Monograph 172.

Osher, F.C., Kofoed, L.L. (1989). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry* 40(10): 1025-1030.

Osher, F.C. (1990). A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry* 66(1): 71-76.

- ***Working with the Criminal Justice System***. Working with the criminal justice system to serve persons who are homeless and mentally ill requires collaboration between the mental health system and the justice system. Here, the keys include the use of boundary spanner staff who can bridge the two systems, jail diversion of persons who can be better served by the mental health system, working with mental health courts, working with local police, and providing mental health services (e.g., continuity of care) in jails.

References:

Center for Mental Health Services (1995). *Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System*. Rockville, MD: Center for Mental Health Services, 1995.

Deane, M.W., et al. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services* 50(1): 99-101.

Morris, S.M., Steadman, H.J. (1994). Keys to successfully diverting mentally ill jail detainees. *American Jails* (July/August): 47-49.

National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Peters, R.H., Hills, H.A. (1997). *Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?* Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services* 52(2): 419-422.

- ***Discharge Planning from Hospitals and Jails***. This is an important area in which there are few evidence-based practices for serving persons who are homeless and mentally ill. Encouraging new directions can be found in both the criminal justice system and the mental health system.

  References:

Interagency Council on the Homeless. (1999). *Exemplary Practices in Discharge Planning: Working Conference on Discharge Planning. Report and Recommendations.* Washington, DC: Interagency Council on the Homeless. (DRAFT)

National Association of State Mental Health Program Directors. (1995). Diversion and jail discharge programs for homeless people with mental illness: Working with the police, the courts, and local jails. *PATHFinder Report*: June.

Veysey, B.M., et al. (1997). In search of the missing linkages: Continuity of care in U.S. jails. *Behavioral Sciences and the Law* 15: 383-397.

Co-Occurring Serious Mental Illnesses and Substance Use Disorders

Although individuals with co-occurring serious mental illnesses and substance use disorders represent a large subpopulation within the mental health and substance abuse treatment systems, the service delivery systems typically do not adequately address their special needs. Subpopulations that may be vulnerable or at high risk for co-occurring disorders include: those with posttraumatic stress disorder (PTSD) – combat veterans, women experiencing domestic violence, and survivors of childhood abuse; those with incarceration histories; homeless persons; and adolescents.

Barriers to treatment of co-occurring disorders include systemic problems, such as the lack of collaboration and cooperation between the

mental health and substance abuse treatment systems and the lack of service provision in correction facilities; service financing and problems with third party payers; and organizational barriers, such as lack of trained staff and agency capacity to address dual disorders and lack of effective outreach to diverse racial and ethnic populations.

Grants under this section are to assist communities in addressing these barriers by enhancing their capacity to provide integrated treatment to individuals with co-occurring psychiatric and substance use disorders. Under this GFA, applicants may request funding in areas: service development, infrastructure development, and community outreach.

- **Service Development Initiatives for Integrated Treatment**. There is a growing evidence base that integrated approaches that incorporate the features of assertive outreach, stage-wise treatment, motivational and harm-reduction approaches, and that is comprehensive and long-term are effective in treating individuals with co-occurring disorders. The essence of integration is that the same clinicians or teams of clinicians (specialists in dual disorders treatment), working in one setting, provide both mental health and substance abuse interventions in a coordinated fashion, with consistent approaches, philosophy, and service plan. Examples of initiatives under this section include, but are not limited to:

  < staff training and/or the adoption (and adaptation, as needed) of an evidence-based integrated service model;
  < enhancement of a currently existing program dual diagnosis program to one that is integrated; or
  < the expansion of a currently existing integrated service model to include new service delivery sites (e.g., jails), new populations (e.g., greater cultural and ethnic diversity in the service population), or a greater number of individuals in the current service population.

- **Infrastructure Development Initiatives**. Grants may be used to foster innovation in service delivery, while grantees build a sustaining infrastructure to maintain their enhanced service delivery capacity after termination of the federal contribution. Examples of initiatives under this section include, but are not limited to:

  < strategic planning and consensus building for service improvement;
  < development of financing strategies for sustainability;
  < development of training and cross-training programs; partnership development between relevant service systems (e.g., mental health, substance abuse, criminal justice);
  < joint ventures for service improvement; or
  < developing culturally competent services and services that include ethic and racially diverse populations.

- **Community Outreach Initiatives**. Grants may be used to expand services within the community. Examples of initiatives under this section include, but are not limited to:

- outreach and engagement to reach those with co-occurring disorders; or
- outreach and engagement addressed to new populations and subpopulations (e.g., working towards greater ethnic and cultural diversity in the agency's client population)

References:

Carey, K.B. (1996). Treatment of co-occurring substance abuse and major mental illness. *New Directions for Mental Health Services* 70: 19-31.

Center for Substance Abuse Treatment. (1994). *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse* (DHHS Publication No. SMA 95-3061). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Drake, R.E., Mercer-McFadden, C., McHugo, G.J., Mueser, K.T., Rosenberg, S.D., Clark, R.E., & Brunette, M.F. (Editors; 1998). *Readings in Dual Diagnosis*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24(4): 589-608.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In Minkoff, K., Drake, R.E. (eds.), *Dual Diagnosis of Major Illness and Substance Abuse Disorder*. New Directions for Mental Health Services 50: 13-27.

Mueser, K.T., Drake, R.E., Miles, K.M. (1997). The course and treatment of substance use disorder in persons with severe mental illness. In Onken, L.S., Blaine, J.D., Genser, S., Horton, A.M. (eds.), *Treatment of Drug Dependent Individuals with Comorbid Mental Disorders*. National Institute of Drug Abuse Research Monograph 172.

Adults in the Criminal Justice System

As correctional populations have burgeoned over the past decade and the number of persons with mental illness living at the fringe of their communities has risen, the absolute number of persons with mental illness who come into contact with the criminal justice system has also escalated. As community-based mental health services have dwindled, access to emergency care, law enforcement departments, and jails have increasingly become *de facto* providers to persons with acute psychiatric and frequently co-occurring substance abuse disorders.

Diversion programs are considered to be one of the primary responses needed to deal with persons with mental illness who are at risk for arrest and incarceration. It is commonly believed that law enforcement and jails working together with other community mental health programs, substance abuse providers, the judiciary, and other community resources can successfully divert offenders who have created misdemeanors.

There is no definitive model for organizing a criminal justice diversion program for persons with co-occurring disorders. When a diversion program is developed, different strategies are needed because local criminal justice systems vary so much in size, structural characteristics, levels of perceived need, resources available within the communities' mental health and substance abuse services network, and local politics and economics. Diversion alternatives to the criminal justice system, whether pre-book or post-book, target interventions for the individual at four important choice points: (1) first police contact; (2) at arraignment; (3) after booking, but prior to trial; and (4) at the time of sentencing.

The goals of various types of diversion are as follows: (1) police based to accomplish diversion before the individual is actually booked into jail; (2) court or post-book diversion to reduce the time spent in jail. In the case of post-book diversion, time in jail may be reduced through pre-trial release or through sentencing alternatives. Court based diversion uses sentencing alternatives and sanctions to structure the course of treatment within or outside of incarceration.

Examples of Promising Practices:

- **Memphis, Tennessee - Police Based Diversion**. The Memphis Pre-Booking Jail Diversion Program consist of Crisis Intervention Trained (CIT) Officers who function as part of the police regular patrol diversion and have received training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, empathy training from mentally ill individuals and family members, legal training in mental health and substance abuse and information resources for those in crisis. The University of Tennessee's Medical Center has an established relationship with CIT Officers and accept all police referrals with no refusals. Diversion staff at the Medical Center work with community providers in developing and implementing appropriate treatment plans for discharged individuals. For more information, contact: (901) 448-4575.

- **Lane County, Oregon - Post-Booking Diversion**. All inmates booked into Lane County Jail are screened for mental health and substance abuse problems. Persons identified are further assessed by the jail-based mental health staff and, in collaboration District Attorney and Public Defender's office, a diversion agreement is presented to the Drug Court. Participants are given one year to complete a an integrated treatment program that is generally delivered in an out-patient setting. Persons requiring further stabilization can be hospitalized at the Lane County Psychiatric Hospital adjacent to the jail. A strong collaboration exists among law enforcement, corrections, the courts, the public mental health clinic, the psychiatric hospital and many private non-profit agencies in order to maximize wrap-around services. For more information, contact: (541) 682-2121.

- **Montgomery County, Pennsylvania - Pre and Post Booking Diversion**. Montgomery County Emergency Services offers both pre-

booking diversion and post-booking diversion with a variety of dispositions to these cases that range from charges being dropped to returning the client to court to responding to the charges filed. The diversion program is supported through police training, a 24-hour crisis response team, inpatient treatment, cases managers, and an outreach team. County Administrators and a local Task Force are also involved in diversion activities - both of which work closely with the Emergency Services to maximize multi-disciplinary involvement in the diversion program. Montgomery County also has specialized probation case loads. For more information, contact: (215) 349-8750.

- **State of Maryland "Phoenix Project" - Post-Booking Diversion for Women and Children**. The "Phoenix Project" springs from a highly successful post-booking program that focuses on dually diagnosed women and their children. Female consumers are diverted pre-arrest by the police and Mobile Mental Health Crisis Team giving the women the option to access secure crisis housing and transitional housing that can accommodate them and their children. This program includes a formal interagency agreement linking local service organizations, regular interagency meetings, formal training for police, a Mobile Crisis Unit with a 24-hour response capacity, an integrated intensive mental illness/substance abuse disorder outpatient treatment program, case management services with a 20:1 client to staff case load, and transitional housing. For more information, contact: (410) 724-3238.

Technical Assistance Resources

The National GAINS Center for People with Co-Occurring Disorders in the Justice System
www. gains@prainc.com, or 1-800-311-4246

This is a national center for the dissemination and application of information about effective mental health and substance abuse services for people with co-occurring disorders
who come into contact with the justice system. The primary focus is to provide practical assistance to help communities design, implement and operate integrated systems. The emphasis is on serving individuals at all stages of the justice system: law enforcement; jails; prisons; probation; and parole. A special emphasis is placed on diversion programs.

Bazelon Center for Mental Health Law
www.bazelon.org, or 202-467-5730

The Bazelon Center sponsors a group on "People with Mental Illness in the Criminal Justice System" that has developed a number of concept papers and principles for systems response to these individuals.

Council of State Governments, Eastern Regional Conference
www.csg.org, or 212-912-0128

The Council of State Governments provides leadership for a national group working on developing a legislative guide to follow for states/communities to use in formulating mental health and criminal justice programs. Technical assistance papers and materials are available to provide background on the issues and promising initiatives underway.

National Mental Health Association
www.nmha.org, or 703-838-7502

The National Mental Health Association Administers a program on the mentally ill in the criminal justice system that develops technical assistance materials, sponsors conferences and meetings, and has been very active in developing a network of state and community based activists.

Youth in the Juvenile Justice System

Listed below are a few examples of evidence-based practices that applicants for Juvenile Justice interventions may wish to consider. Under each are a few references and/or contacts that can provide additional information for that intervention type. Additional references are listed at the end of the Juvenile Justice section of this appendix. The type of program selected obviously will depend upon the point of system involvement of the target population. Applicants are not limited to the interventions listed here, but the chosen intervention must be strength-based and evidence-based.

- **Functional Family Therapy**. This is a strength-based, family-based intervention model for delinquent and/or substance abusing youth. For more information, contact: The Center for the Study and Prevention of Violence (303) 492-8465.

  Reference:

  Alexander, J. et. al.(1998). *Blueprints for Violence Prevention. Book Three: Functional Family Therapy*. Golden, CO: Venture Publishing.

- **Multidimensional Treatment Foster Care**. This is an intensive intervention with trained and supervised foster care families to provide positive behavior management and a therapeutic environment. For more information, contact: Patricia Chamberlain, Oregon Social Learning Center, (541) 485-2711, or the Center for the Study and Prevention of Violence, (303) 492-8465.

  Reference:

  Chamberlain, P. and Mihalic, S.F.. (1998). *Blueprints for Violence Prevention. Book Eight: Multidimensional Treatment Foster*

Care. Golden, CO: Venture Publishing

- **Moral Reconation Therapy.** This is a cognitive behavioral program typically implemented within a placement setting. (**Note**: The evidence-base established at the adult level thus far, but program also used in juvenile settings with promising results. It may be used at the juvenile level for this initiative.)

  Reference:

  Little, G.L. et. al. (1998). "Nine year reincarceration study on MRT-treated felony offenders: Treated offenders show significantly lower reincarceration." *Cognitive Behavioral Treatment Review* 7 (1): 2-3.

- **Multi-Systemic Therapy.** This is a home family-based intervention for delinquent and/or substance abusing youth. For more information, contact: Scott Henggeler, Family Services Research Center, (843) 876-1800, or Keller Strother, MST, Inc., (843) 856-8226, x11.

  Reference:

  Henggeler, S. et. al. (1998). *Blueprints for Violence Prevention. Book Six: Multisystemic Therapy*. Golden, CO: Venture Publishing.

- **Aggression Replacement Training**. This is a cognitive behavioral program designed to reduce anti-social behavior, typically implemented in a placement setting.

  Reference:

  Goldstein, A. and Glick, B. (1995). Aggression replacement training for delinquents. In Ross, R. et. al. (eds.) *Going Straight, Effective Delinquency Prevention and Offender Rehabilitation.* Ottawa: AIR Training Publications, Ch. 6.

- **Adolescent Diversion Project**, supportive community-based intervention for youth diverted from the juvenile justice system.

  Reference:

  Davidson, W. and Redner, R. (1988). The prevention of juvenile delinquency: Diversion from the juvenile justice system. In R. H. Price et. al. (eds.) *14 Ounces of Prevention: A Casebook for Practitioners* (p. 123-137). Washington, D.C.: American Psychological Association.

- **Bethesda Day Treatment.** This is a program of multiple-level community based services. For more information, contact: Bethesda Family Services Foundation, Inc., Central Oak Heights, Box 210, West Milton, Pennsylvania 17886, (717) 568-2373.

Additional References**:**

Catalano, R.F. and Hawkins, J.D. (1995). The social development model: A theory of anti-social behavior. In J.D. Hawkins (ed.) *Delinquency and Crime: Current Theories*, p. 149-197. New York: Cambridge University Press.

Cooper, W. O., et. al. Components of effective youth violence prevention programs for 7- to 14- year-olds. *Archives of Pediatric Adolescent Medicine* 154:1134-1139.

Kumpfer, K. and Alvarado, R. Effective family strengthening interventions. *Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin*, November 1998.

Office of Juvenile Justice and Delinquency Prevention: http://ojjdp.ncjrs.org.

Tremblay R. and Craig, W. (1995). Developmental crime prevention. In M. Tonry and D. Farrington (eds.) *Building A Safer Society. Crime and Justice, vol 19.* Chicago: University of Chicago Press.

Racial and Ethnic Minorities

Grants under this section will focus on the elimination of Mental Health disparities in the four largest racial/ethnic minority groups in the U.S. This includes African Americans (Blacks), American Indians and Alaskan Natives, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans. These four racial/ethnic minority groups together comprise almost 30 percent of the total population, and are projected to comprise the majority of the U.S. population by the year 2025. These rapidly changing demographics bring new challenges to a mental health system that is already filled with gaps in programs and services available to serve racial/ethnic minorities, and the need to address barriers to mental health services, including the lack of access to care and low utilization, few bilingual/bicultural service providers, mistrust, stigma/shame, fear, and the inability to pay for services. As stated in the Report of the Surgeon General on Mental Health, "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age and gender"(1999:vi).

Mental health services can be more responsive to ethnic and racial minorities through the implementation of culturally competent services. These services are those who demonstrate an understanding of the client/consumer's language, an appreciation and respect of cultural values, cultural and political histories, spiritual practices and beliefs, as well as a thorough examination of the role of family and community engagement. All

measures require that service systems and professionals be responsible for building capacity (culturally/linguistically competent professionals, infrastructure and sustainability), create relevant services that contain cultural/linguistic competencies, as well as incorporate an appreciation of the unique strengths, assets and protective factors possessed within each individual and group.

References:

Cross, T. et al. (1989). *Towards a culturally competent system of care*. Washington, DC: CAASP Technical Assistance Center.

Center for Mental Health Services (2000). *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underreepresented Racial/Ethnic Groups*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist* 53:440-448

Sue, S. et al. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Counsulting and Clinical Psychology* 59:533-540.

U.S. Department of Health and Human Services. Mental Health (1999). *A Report of the Surgeon General*. Rockville, MD: U.S. Department of Human Services, Substance Abuse and Mental Health Administration, Center For Mental health Services, National Institutes of health, national Institute of Mental Health.

Federal Resources Useful To All Applicants

Substance Abuse and Mental Services Administration (SAMHSA), www.samhsa.gov

SAMHSA's mission within the Nation's health system is to improve the quality and availability of prevention, treatment, and rehabilitation services to reduce illness, death, disability, and cost to society from substance abuse and mental illnesses. SAMHSA has three centers. The Center for Mental Health Services and the Center for Substance Abuse Prevention are listed below.

Center for Mental Health Services (CMHS), www.mentalhealth.org

CMHS, within SAMHSA , provides national leadership to prevent and treat mental disorders; improve access and promote high-quality services for people with, or at risk for, these disorders; and promote improvement of mental health for all Americans and rehabilitation services for individuals with mental illness.

Center for Substance Abuse Prevention (CSAP), www.samhsa.gov/csap/index.htm

CSAP, within SAMHSA, provides national leadership in the Federal effort to prevent alcohol, tobacco, and illicit drug problems.

National Institute of Mental Health (NIMH), www.nimh.nih.gov

NIMH conducts and supports research nationwide on mental illness and mental health, including studies of the brain, behavior, and mental health services. NIMH is the foremost mental health research organization in the world, with a mission dedicated to improving the mental health of the American people; fostering better understanding of effective diagnosis, treatment, and rehabilitation of mental and brain disorders; and supporting research on interventions to prevent mental illness or to reduce the frequency of recurrent episodes of mental illnesses and their disabling consequences.

Appendix III: Consumer and Family Participation Guidelines

Applicants should have experience or track record of involving mental health consumers and their family members. The applicant organization should have a documented history of positive programmatic involvement of recipients of mental health services and their family members. This involvement should be meaningful and span all aspects of the organization's activities as described below:

Program Mission. An organization's mission should reflect the value of involving consumers and family members in order to improve outcomes.

Program Planning. Consumers and family members are involved in substantial numbers in the conceptualization of initiatives including identifying community needs, goals and objectives, and innovative approaches. This includes participation in grant application development including budget submissions. Approaches should also incorporate peer support methods.

Training and Staffing. The staff of the organization should have substantive training in and be familiar with consumer and family-related issues. Attention should be placed on staffing the initiative with people who are themselves consumers or family members. Such staff should be paid commensurate with their work and in parity with other staff.

Informed Consent. Recipients of project services should be fully informed of the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time.

Rights Protection. Consumers and family members must be fully informed of all of their rights including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of healthcare information, complaints and appeals, and consumer responsibilities.

Program Administration, Governance, and Policy Determination. Consumers and family members should be hired in key management roles to provide project oversight and guidance. Consumers and family members should sit on all Boards of Directors, Steering Committees and Advisory bodies in meaningful numbers. Such members should be fully trained and compensated for their activities.

Program Evaluation. Consumers and family members should be integrally involved in designing and carrying out all research and program evaluation activities. This includes determining research questions, designing instruments, conducting surveys and other research methods, and analyzing data and determining conclusions. This includes consumers and family members being involved in all submission of journal articles. Evaluation and research should also include consumer satisfaction and dissatisfaction measures.

Appendix IV: Definitions

- **Children and adolescents** targeted for prevention and early intervention services for the purposes of this announcement include infants, toddlers, preschool and school-aged children and adolescents from the prenatal stage to 18 years old.

- **Homeless persons** are those who lack a fixed, regular, and adequate nighttime residence, including residents of supervised public or private shelters and time-limited transitional housing, public or private facilities not designed as regular sleeping accommodation for human beings, and other nonpermanent nonresidential accommodations.

- **Persons with co-occurring disorders** for the purposes of this announcement are those with co-existing serious mental illnesses and alcohol and/or drug use disorders. The term does not connote a single problem as there is considerable variability in the combination and presentation of dual disorders.

- **Adults in the criminal justice system** include persons engaged in one or more sequential steps which include police contact; pre-trial jail services, including booking and arraignment; trial and sentencing; court-mandated disposition to incarceration in post-trial jail or prison; and finally, probation and parole with conditions of release that are designed to result in eventual discharge. The definition of "adult" may vary from State to State.

- **Diversion from the criminal justice system** refers to specific programs available to some individuals who have committed misdemeanors and other non-violent actions where mental health intervention places people in the community instead of keeping them in jail. These individuals may be identified for diversion at any point, including pre-booking intervention (before formal charges are filed) and post-booking interventions (after the person has been arrested and jailed). These interventions can occur through police de-escalation with psychiatric/medical treatment to dropping criminal charges, deferring prosecution, or by imposing conditions of bail or probation.

- **Youth in the juvenile justice system** refers to youth referred to or are under the jurisdiction, supervision, and/or custody of the State or local juvenile justice system. The age of these clients will vary from State to State depending upon jurisdictional law.

- **Racial groups**, for the purposes of this announcement, are defined as:

  - *American Indian or Alaska Native*--a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
  - *Asian*-a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- < *Black or African American*--a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- < *Native Hawaiian or Other Pacific Islander*---a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- < *White*---a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

C Hispanic or Latino culture or origin, for the purposes of this announcement, is defined as:

- < *Hispanic or Latino*--a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

C **Cultural competence** means attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations. This includes an understanding of a group's or member's language, beliefs, norms and values, as well as socioeconomic and political factors which may have significant impact on their psychological well-being, and incorporating those variables into assessment and treatment.

C An **evidence-based practice** is one with documented *effectiveness* (evidence that the practice will change or have an impact upon the target of intervention), *applicability* (evidence that the practice will be effective with clients from the specified target population), and *replicability* (evidence that the practice can be implemented with fidelity to the original model while achieving similar results). The higher the level of evidence, the more likely the program is to work in other settings. In 1998, the U.S. Preventive Services Task Force articulated the following ***levels of evidence***:

- < Evidence obtained from at least one properly designed randomized controlled trial.
- < Evidence obtained from well-designed controlled trials without randomization.
- < Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
- < Evidence obtained from multiple time series with or without the intervention, or dramatic results in uncontrolled experiments.
- < Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

C **Non-mental health service sites** include primary health care agencies, homeless shelters, faith-based organizations, private residences, schools, juvenile justice facilities, adult detention and incarceration facilities, addiction service agencies and other locations where the priority populations are located.

C **Mental health** is defined by the Surgeon General as a state of successful performance of mental function, resulting in the capacity to be productive in various domains of living including the establishment of satisfying relationships and the ability to approach difficult

circumstances with resilience, and not simply the absence of mental illness.

- **Mental illness** as defined by the Surgeon General, refers collectively to all of the diagnosable mental disorders mediated by the brain and characterized by abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities.

- **Psychiatric disorder** refers to the condition of currently having, or at any time during the past year having had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV (Axis I). These disorders include any mental disorders listed in Axis I of the DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders, mental retardation, and developmental disorders, which are excluded unless they co-occur with another diagnosable psychiatric disorder meeting the above criteria. All of these disorders may have episodic, recurrent, or persistent features, and may vary in terms of severity and disabling effects.

- **Risk factors** are defined by the Surgeon General as biological, psychological, or sociocultural variables that increase the probability for developing a disorder and antedate its onset.

- **Protective factors** are defined by the Surgeon General as those variables that improve a person's response to some environmental hazard resulting in an adaptive outcome.

- **Prevention** refers to interventions that occur before the initial onset of a mental disorder to prevent the development of the disorder including the prevention of comorbidity. Interventions can be classified into three categories: *universal* (everyone in a specific population, e.g., elementary school children receive general life skills training), *selective* (a subgroup of a larger population with heightened risk, e.g., second graders who show signs of interpersonal difficulty receive a specific targeted protocol), and *indicated* (individuals at the highest risk for the development of a mental or behavioral disorder and who may exhibit symptoms of a disorder insufficient for a clinical diagnosis, e.g., children with aggressive behavior who receive an individual intervention as well as an intervention designed to assist their parents and teachers who must respond to the child's problem behavior).

- **Early intervention** refers to interventions that are targeted for individuals who for the first time display the early signs and symptoms of a mental disorder.

- A program **logic model**, or flow chart, is a graphic representation of what the program is designed to accomplish, including services to be delivered, expected outcomes of these services, and ultimate program goals linked to the underlying assumptions of the program. In addition, a good logic model is a picture of plausible causal linkages between program components and outcomes and can serve as an evaluation map, identifying what services need to be documented in a process evaluation and what outcomes need to be measured in an

outcomes evaluation (see Appendix I).

Appendix V: CMHS GPRA Client Outcomes

Measures for Discretionary Programs

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client; to the extent that providers already obtain much of this information as part of their ongoing client intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 16-105, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2002

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type 1. INTAKE 2. 6 month follow-up 3. 12 month follow-up

B. DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

m. Any Alcohol |____|____|

b. Alcohol to intoxication (5+drinks in one sitting) |____|____|

c. Illegal Drugs |____|____|

2. During the past 30 days, how many days have you used any of the following: **Number of Days**

a. Cocaine/Crack |____|____|

b. Marijuana/Hashish [Pot, Joints, Blunts, Chronic, Weed, Mary Jane] |____|____|

c. Heroin [Smack, H, Junk, Skag], or other opiates |____|____|

d. Non prescription methadone |____|____|

e. Hallucinogens/psychedelics, PCP [Angel Dust, Ozone, Wack, Rocket Fuel] MDMA, [Ecstacy, XTC, X, Adam], LSD [Acid, Boomers, Yellow Sunshine], Mushrooms, Mescaline |____|____|

f. Methamphetamine or other amphetamines [Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank] |___|___|

g. Benzodiazepines, barbiturates, other tranquilizers, Downers sedatives, or hypnotics, [GHB, Grievous Bodily Harm, Georgia Home Boy, G, Liquid Ecstacy; Ketamine, Special K, K, Vitamin K, Cat Valiums; Rohypnol, Roofies, Roche] |___|___|

h. Inhalants [poppers, snappers, rush, whippets] |___|___|

i. Other Drugs - Specify_____ |___|___|

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time?

- ○ Shelter (Safe havens, TLC, low demand facilities, reception centers, Other temporary day or evening facility)
- ○ Street/outdoors (sidewalk, doorway, park, public or abandoned building)
- ○ Institution (hospital., nursing home, jail/prison)
- ○ Housed (Own, or someone else's apartment, room, house halfway house, residential treatment)

5. During the past week, to what extent have you been experiencing difficulty in the area of:
Managing day-to-day life (e.g., getting to places on time, handling money, making every day decisions)

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme Difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

6. During the past week, to what extent have you been experiencing difficulty in the area of:

Household responsibilities (e.g., shopping, cooking, laundry, keeping your room clean, other chores)

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

7. During the past week, to what extent have you been experiencing difficulty in the area of:

Work (e.g., completing tasks, performance level, finding or keeping a job)

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

8. During the past week, to what extent have you been experiencing difficulty in the area of:
School (e.g., academic performance, completing assignments, attendance)

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

9. During the past week, to what extent have you been experiencing difficulty in the area of:
Leisure time or recreational activities

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

10. During the past week, to what extent have you been experiencing difficulty in the area of:
Developing independence or autonomy

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme Difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

11. During the past week, to what extent have you been experiencing difficulty in the area of:
Apathy or lack of interest in things

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

12. During the past week, to what extent have you been experiencing difficulty in the area of:
Confusion, concentration or memory

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

13. During the past week, to what extent have you been experiencing difficulty in the area of:
Feeling satisfaction with your life

- ○ No difficulty
- ○ A little difficulty
- ○ Moderate difficulty
- ○ Quite a bit of difficulty
- ○ Extreme difficulty
- ○ Don't know
- ○ Not Applicable
- ○ Refused

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? [IF ENROLLED: Is that full time or part time?]

- ○ Not enrolled
- ○ Enrolled, full time
- ○ Enrolled, part time
- ○ Other (specify)_____

2. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

2a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

○ Yes ○ No

3. Are you currently employed? [Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work]

- ○ Employed full time (35+ hours per week, or would have been)
- ○ Employed part time
- ○ Unemployed, looking for work
- ○ Unemployed, disabled
- ○ Unemployed, Volunteer work
- ○ Unemployed, Retired
- ○ Other Specify_____

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

INCOME

a. Wages	$				,				.00
b. Public assistance	$				,				.00
c. Retirement	$				,				.00
d. Disability	$				,				.00
e. Non-legal income	$				,				.00
f. Other_____ __ (Specify)	$				,				.00

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested? |____|____| times

2. In the past 30 days, how many times have you been arrested for drug-related offenses? |____|____| times

3. In the past 30 days, how many nights have you spent in jail/prison? |____|____| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

2. During the past 30 days, did you receive

a. Inpatient Treatment for:	No	Yes	**If yes, altogether** for how many nights (DK=98)
I. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

b. Outpatient Treatment for:	No	Yes	**If yes, altogether** how many times (DK=98)
I. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

c. Emergency Room Treatment for:	No	Yes	**If yes, altogether** for how many times (DK=98)
I. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

H. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female
- ○ Other (please specify) _____

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race? (Select one or more)

○	Black or African American	○	Alaska Native
○	Asian	○	White
○	American Indian	○	Other (Specify)_____
○	Native Hawaiian or other Pacific Islander		

4. What is your date of birth? |____|____| / |____|____| / |____|____|
Month / Day / Year